Swing Bed Patient Activity Plan

Patient Name: _____

Date of Assessment: _____

Assessment of Patient's Activity Needs: _____

Activity Plan of Care: _____

Weekly Progress Meeting Plan of Care and/or Modifications to Plan of Care: Week 1:

Weekly Progress Meeting Plan of Care and/or Modifications to Plan of Care: Week 2:

Weekly Progress Meeting Plan of Care and/or Modifications to Plan of Care: Week 3:

Patient/Family Signature: _____

Staff Name (printed) & Title: _____

Staff Signature & Date: _____